WiRO

WorkCover independent review office

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RECOMMENDATION FOLLOWING AN APPLICATION FOR REVIEW OF THE INSURER'S WORK CAPACITY DECISION PURSUANT TO SECTION 44(1)(c) OF THE *WORKERS COMPENSATION ACT* 1987.

SUMMARY:

a. **The work capacity decision of the Insurer dated 27 November 2013 is set aside.**

b. **The applicant is to be reinstated to her weekly payments at the rate applicable at 27 November 2013.**

c. **The payments are to be back-dated to 18 April 2014.**

d. **The payments are to continue until such time as a further work capacity decision is made and comes into effect.**

1. The applicant seeks procedural review of a work capacity decision made by the Insurer on 27 November 2013. The decision stated that payments were to cease on 5 March 2014. The applicant sought internal review. The Internal Review Decision (IRD) was issued on 10 January 2014. The IRD purported to extend the date for cessation of weekly payments to 18 April 2014. The applicant sought Merit Review by the Authority. That application was received by the Authority on 12 February 2014. The Merit Review decision was issued on 8 May 2014, some 85 days later.[1]

2. The applicant was injured on 22 August 2002. She returned to suitable employment with the employer until January 2006. Since that time the applicant has been employed in suitable duties with another employer. The Insurer made weekly payments as required under the provisions of the *Workers Compensation Act* 1987 (1987 Act).

3. The applicant was in receipt of compensation by way of weekly payments immediately before 1 October 2012. Accordingly Clause 8 of Part 19H of Schedule 6 to the 1987 Act required the Insurer to conduct a work capacity assessment for the purpose of facilitating the application of the amended weekly benefits provisions to the applicant's claim. Clause 17 of Schedule 8 to the Workers Compensation Regulation 2010

[1] Cf: *Review Guideline* 10.14 (as amended).

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(the Regulation) required the transitioning process to be completed *"within 18 months"* of 1 October 2012.

4. The relevant version of the WorkCover Work Capacity Guidelines *(Guidelines)* is the one dated 4 October 2013, published on 8 October 2013, and which came into effect on 11 October 2013. The *Guidelines* provide instructions and guidance to Insurers regarding the appropriate and consistent application of work capacity assessments and decisions.

5. Once the Insurer has conducted an assessment then the Insurer is required to make a work capacity decision. Where that decision involves a reduction in or cessation of the weekly benefits payable to the injured worker then the Insurer is required to give proper notice to the worker (see section 54(2)(a) of the 1987 Act).

Submissions by the applicant

6. The applicant raised various matters in the Application for Procedural Review. Section 44(1)(c) of the 1987 Act states that this review is "*only of the insurer's procedures in making the work capacity decision and not of any judgment or discretion exercised by the insurer."* The applicant's submissions went to the merits of the case, that is, the very object of judgement or discretion of the Insurer excluded by section 44(1)(c) and therefore could not be relevant to this review.

Submissions by the insurer

7. The Insurer's submissions were to provide a copy of the fair notice letter as required by *Guideline* 5.2 and a copy of the acknowledgement of internal review.

The Decision

8. The fair notice letter and telephone call took place on 28 June 2013. These must take place at least 2 weeks prior to the decision, but no maximum time period is mandated. The period in this case is nearly 22 weeks. It is arguable that this is too long a period. The fair notice letter has, however, a more serious fault. Guideline 5.2 requires the Insurer to *"explain the potential outcome of this review and detail the information that has led the insurer to their current position".* The letter does not set

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out any information other than to list 3 documents. It is not stated that those documents contain any relevant information. The letter states that the *"decision may result in a recalculation or discontinuation of your weekly compensation under Section 36, 37 or 38 of the 1987 Act."* A recalculation may mean an increase in the weekly payment. An experienced Senior Case Manager, who had the decision reviewed and confirmed by another Senior Case Manager, should have been able to advise that the most likely outcome would be cessation of weekly payments. Sections 36 and 37 are irrelevant to the applicant's case.

9. The decision states that a work capacity assessment was undertaken. The IRD reveals that it was undertaken on 30 October 2013. There does not appear to be any legislative requirement to notify the applicant of the outcome of the assessment. However, *Guideline* 5.3.2 stated that the decision must:

   - *state the decision and give brief reasons for making the decision;*
   - *outline the evidence considered in making the decision, noting the author, the date and any key information. All evidence considered should be referred to, regardless of whether or not it supports the decision;*
   - *clearly explain the line of reasoning for the decision.*

   My finding is that the *Guidelines* result in the insurer being compelled to reveal the outcome of the assessment which would involve showing the date of the assessment.

10. The decision does not state that the assessment is required pursuant to Clause 8 of Part 19H of Schedule 6 to the 1987 Act. As such the legislation has not been properly referenced as *Guideline* 5.3.2 requires.

11. *Guideline* 5.3.2 required the decision to *"reference the relevant legislation."* This would require any interpretation of the legislation (including delegated legislation) to be accurate. It is clearly inaccurate to say (as this Insurer has said) that the claim *"must transition to the new benefits system in 2013."* What Clause 8(2) of Pt 19H of Schedule 6 to the 1987 Act requires is for the Insurer to conduct a work capacity

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assessment (for the purposes of transitioning a claim) *"no later than 12 months (or such longer period as may be prescribed by the regulations) after the commencement of the weekly payments amendments."* While the amendments commenced on 1 October 2012, the *Workers Compensation Regulation* 2010 says at Clause 17, Schedule 8 that *"a period of 18 months is prescribed for the purposes of Clause 8(2) of Part 19H of schedule 6 to the 1987 Act."* It follows that there was no requirement for the Insurer to conduct a work capacity assessment and for the claim to be transitioned *"in 2013."*

12. *Guideline* 5.3.2 requires the Insurer *"to state the impact of the decision on the worker in terms of their entitlement to weekly payments, entitlement to medical and related treatment expenses and return to work obligations."* Section 59A(2) of the 1987 Act provides that treatment expenses and related expenses are no longer payable 12 months after weekly payments cease. The decision states that *"any entitlement you may have to payment of pre-approved reasonable and necessary medical and other expenses will be limited for up to 12 months after your entitlement to weekly payments cease. Please refer to: Section 59A"* of the 1987 Act. The legislation has not been properly referenced as required by *Guideline* 5.3.2. The correct reference is to section 59A(2) of the 1987 Act. The manner in which such medical expenses will be limited is not stated. An applicant may believe that certain types of treatment, such as skiagrams or treatment by a remedial gymnast (to give only two illustrative examples), are not permitted during the 12 month period. Perhaps there is a financial limit on treatment that may be received. Section 59A(2), however, placers no limits on types or amount of treatment. That section provides that payment for medical treatment *per se* ceases 12 months after weekly payments cease.

13. The next sentence in the decision is "*this means that your entitlement to medical and related expenses will cease on 11 January 2015. Please refer to: Section 59A"* of the 1987 Act. The legislation has, again, not been properly referred to. More significantly, the applicant is likely to be left with the view that payment of medical expenses will cease after 12 months, and during that 12 month period there are certain limits on types or amount of treatment to which she is entitled.

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14. In addition, section 59A(3) of the 1987 Act states that the applicant may, after the entitlement to compensation for medical expenses ends, become eligible for further payments for medical expenses if the applicant becomes entitled to compensation for weekly benefits at some stage in the future and for such time as those weekly payments continue. This was not disclosed by the Insurer.

15. The applicant has received 479.2 weeks of compensation as at the date of the decision. The decision states that as a result weekly payments are to be assessed pursuant to section 39 of the 1987 Act. Section 39 deals with weekly payments after 260 weeks of payments. The applicant has received more than 260 weeks of payments, but section 39 does not apply to periods before the commencement of the 2012 amendments: see Clause 13, Part 19H of Schedule 6 to the 1987 Act. Section 39 is irrelevant in the applicant's current circumstances and the applicant has been misinformed.

16. The decision sets out the relevant formula for payments after 260 weeks, but fails to refer to the fact that the formula is in section 38(7) of the 1987 Act in the applicant's case, and not in section 39.

17. The decision states that as a result of the assessment that the applicant has *"a current capacity to work and have returned to work for not less than 15 hours per week: Please refer to Section 43(1)(a) of"* the 1987 Act. Section 43(1)(a) would be of no assistance in explaining *"current work capacity".* Section 32A of the 1987 Act defines *"current work capacity"* which is itself defined by reference to *"suitable employment*." The definition of "suitable employment" is set out, but not *"current work capacity".* That term means being unable to return to pre-injury employment, but being able to work in *"suitable employment".* Such a definition would occur to very few people.

18. Further into the decision the applicant is advised that she has been assessed as earning a certain amount in suitable employment which is her current employment. Suitable employment is then described in 2 paragraphs. At the end of the second paragraph reference is made to section 32A. It would not be clear to an applicant that both paragraphs are relevant in relation to section 32A.

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19. The applicant is advised that her *"average weekly earnings"* is the transitional amount. The decision does not refer to Clause 2, Part 19H of Schedule 6 to the 1987 Act which is where the transitional amount is set out. It is then stated that the transition amount *"must be used for any workers who made their claim prior to 1 October 2012 to transition to the new benefits system: Please refer to: Section 43(1)(d) of the Workers Compensation Act 1987".* That is erroneous. The transition amount must be used for an applicant who was in receipt of weekly benefits immediately before 1 October 2012 pursuant to clause 1, Part 19H of Schedule 6 to the 1987 Act.[2] Section 43(1)(d) is unlikely to assist the applicant in understanding the nature and applicability of the transitional rate.

20. The applicant is advised that she may request an internal review. The Insurer has not referred to section 44(1)(a) of the 1987 Act. This is a breach of *Guideline* 5.3.2 and the need to *"reference the relevant legislation."* The Insurer states that the request can be made by facsimile or email. The Insurer does not say that such a request can be made by post. This error by omission is the more unusual for the decision itself being only capable of service either in person or by post.

21. The application for internal review is said to be required to be lodged within 30 days of receipt of the decision. That is not correct. Section 44(1)(a) of the 1987 Act does not set any time limit in which the application for internal review is to be made. *Guideline* 7.2.2 refers to *"timely lodgement".* A time frame of 30 days may well be appropriate, but no assistance is given as to what may constitute *"timely lodgement."*

22. The decision states that "*frivolous and vexatious applications may be rejected".* The Insurer does not have the ability pursuant to section 44(1)(a) of the 1987 Act to refuse a request for internal review on that basis. The Authority and the Independent Review Officer may pursuant to section 44(3)(b) refuse to entertain an appeal where it is frivolous or vexatious, not frivolous and vexatious.

[2] By chronological force an applicant must have made a claim before 1 October 2012 in order to be in receipt of weekly payments as at that date. Hence the making of a claim is a necessary pre-condition to the receipt of payments, the latter being the only sufficient condition for being styled an "existing recipient of weekly payments" under the 1987 Act.

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23. The advice as to the internal review states that the application form should be completed and "*returning it to us with the extra information, reports and/or documents you rely upon*" (emphasis added). This statement conveys the impression that an applicant must provide further evidence or information in order to make an application for internal review. That is misleading. The applicant may request an internal review pursuant to section 44(1)(a) of the 1987 Act, which has not been referred to, whether or not further evidence or information is available or submitted. The applicant is only required to provide "*grounds*" in an application for internal review as required by *Guideline* 6.2.2, *Review Guideline* 6.2 and section 44(2) of the 1987 Act.

24. The applicant is advised that if she is dissatisfied with the internal review she may seek a merit review from WorkCover. Again, the Insurer has not referred to section 44(1)(b) of the 1987 Act. The applicant is also advised that WorkCover will *"provide a response to you within 30 days of receipt of your request."* The *Guidelines for work capacity decision Internal Reviews by Insurers and Merit Reviews by the Authority* 10.14 states "*The Authority will write to the worker and insurer as soon as practicable and preferably within 30 days of receiving the application advising of the outcome of the merit review."* The Authority took 85 days. It seems that *Guideline* 10.14 is one for breach of which there exists no current remedy.[3]

25. At the end of the decision and purporting to form part of the decision are 6 pages of extracts from the 1987 Act under the heading *"Key Sections of the Workers Compensation Act NSW 1987 referred to within this Notice".* That is incorrect as some parts of the extract are in the decision, some are not and there is no reference to the *Regulation*. Setting out large swathes of the 1987 Act under a misleading heading is not helpful. By way of example sections 36 and 37 of the 1987 Act are included, and are not relevant to the applicant's case. The decision relies on section 39 of the 1987 Act, but that is not reproduced. Section 32A is set out in full. Many definitions in that section are of no relevance to the applicant.

FINDING

[3] See footnote 1.

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26. I find that the Insurer has failed to follow the procedures as set out in the WorkCover *Guidelines* which is required by Section 44A of the 1987 Act. The Insurer has also failed to follow the 1987 Act and the *Workers Compensation Regulation* 2010.

RECOMMENDATION

27. I recommend that the Insurer conduct a new work capacity assessment in accordance with the WorkCover *Guidelines* and make a new work capacity decision.

28. I recommend that the Insurer pay the applicant the weekly benefit to which she was entitled prior to 27 November 2013 until such time as she is properly transitioned. Those payments should continue from 18 April 2014 being the date on which they ceased.

29. Since the applicant is not currently in receipt of weekly payments, clause 21 of schedule 8 of the *Regulation* cannot apply and payments may resume immediately. The applicant is not required to produce work capacity certificates for the period from 18 April 2014 to date by virtue of the operation of section 44B(2) of the 1987 Act. These recommendations are binding on the insurer: see section 44(3)(h) of the 1987 Act.

Wayne Cooper
Delegate of the WorkCover Independent Review Officer
13 June 2014